# The Health of New Hampshire's Community Hospital System

*A Financial Analysis*

## Southern New Hampshire Medical Center




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**An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services**

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# Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

# Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

| **Profitability:** | Purpose | Calculation |
|---|---|---|
| Total Margin | Measures the organization's ability to cover expenses with revenues from all sources | Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues |
| Operating Margin | Measures the organization's ability to cover operating expenses with operating revenues | Ratio of Operating Income/Total Operating Revenue |
| PPS Payment/Cost | Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs | Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports |
| Non-PPS Payment/Cost | Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1] | Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs) |
| Markup Ratio | Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges | Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense |
| Deductible Ratio | Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges | Ratio of Contractual Adjustments/Gross Patient Service Revenue |
| Nonoperating Revenue Contribution | Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit | Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense |
| Realized Gains to Net Income | Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit | Ratio of realized gains (losses)/Excess Revenue over Expense |

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

| | | |
|---|---|---|
| **Liquidity:** | | |
| Current Ratio | Measures the extent to which current assets are available to meet current liabilities | Current Assets/Current Liabilities |
| Days in Accounts Receivables | Measures how quickly revenues are collected from patients/payers | Patient Accounts Receivable/(Net Patient Service Revenue / 365) |
| Average Pay Period | Measures how quickly employees and outside vendors are paid by the hospital | (Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2] |
| Days Cash on Hand | Measures how many days the hospital could continue to operate if no additional cash were collected | (Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses) |
| **Solvency:** | | |
| Equity Financing Ratio | Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid) | Unrestricted Net Assets/Total Assets |
| Cash Flow to Total Debt | Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities | (Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities |
| Average Age of Plant | Measures the relative age of fixed assets | Accumulated Depreciation/ Depreciation Expense |

## Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

## Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

## Acknowledgements

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### For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

**MOODY'S BOND RATING: BAA1**
**STANDARD & POOR'S BOND RATING: A-**

# SOUTHERN NEW HAMPSHIRE MEDICAL CENTER
# NASHUA, NEW HAMPSHIRE
# 1993 – 1999 FINANCIAL ANALYSIS

Southern New Hampshire Medical Center, formerly Nashua Medical Center, is a 154 acute-care bed hospital located in Hillsborough County[3]. As of 1997, private insurers represented the largest percentage of payers for inpatient discharges (56%)[4].

In 1996, the hospital simultaneously merged with its parent company, Nashua Memorial Health System, and Lahey Hitchcock Nashua. These entities combined became Southern New Hampshire Regional Medical Center. As a result of the merger, the medical center became the parent company to Southern New Hampshire Regional Foundation, a not-for-profit (NP) physician group practice, and Lahey Hitchcock Corporation, Inc. (NP) became the parent company to the medical center. In 1997, LHC was dropped as the parent company, and by 1998, Southern New Hampshire Health System, Inc. became the parent. At this time, the Foundation was renamed "Foundation Medical Partners, Inc.", and the medical center dropped "Regional" from its name. Financial statements reflect the performance of the medical center only.

## Summary of Financial Analysis 1993-98

The medical center's financial performance over the period was strong. Operating profitability drove total margins, and nonoperating gains, specifically realized gains on the sale of investments, grew and enhanced the bottom line. Improved profitability, liquidity and solvency indicators demonstrated financial health.

## Cash Flow Analysis 1993-98

Over the six-year period, the medical center generated most of its capital internally. Total income generated 40% of the total cash sources, half of which was produced by operating income (21% of total cash sources). Cash from depreciation expense generated an additional 23% of total cash sources. Internally generated capital was augmented by debt sources, which generated one-third of the total cash.

Cash was used mostly to invest in property, plant and equipment (PP&E) (48% of total cash uses). This amount of investment was more than twice the depreciation expense over the period, but the average age of plant increased almost 2 years from its low of 7.05, reaching 9 years in 1998.

Investments in marketable securities used 18% of cash, and equity transfers another 18%. Over the six-year period, transfers to affiliates used almost $18M, most of which went to the physician practice (over $12M between 1995 and 1998), whose cumulative losses were reported as $6M between 1995 to 1997. Prior to 1995, the physician practice was a subsidiary to the System and details about its performance were not provided, though transfers from the medical center to the System did occur during this time.

[3] 1997 American Hospital Association Guide.
[4] 1997 data from the State of New Hampshire Department of Health and Human Services.

The overall pattern of cash flows represents a healthy, viable hospital, although its losses on investments in physician practices represent a potential long-term problem, particularly if operating profits decline.

## Ratio Analysis 1993-98[5]

***Profitability***

The medical center's profitability was strong. Total margins increased steadily from 1993 to 1998 and were driven by operating margins.

The operating margin was strong and increased as the markup of charges above cost grew faster than payer discounts and contractuals (deductible) in most years. At 1.85 in 1998, the markup is one of the highest in the state.

Growth in nonoperating revenues, specifically realized gains on the sale of investments, enhanced the already strong bottom line. In recent years, realized gains contributed over one-third of the bottom line, pushing the total margin to 15% by 1998. Even without realized gains, profitability would have remained strong due to the high operating margins.

***Liquidity***

The medical center's liquidity improved over the period to a sound 2.11 current ratio by 1998. The current ratio steadily increased from 1993 to 1998, a favorable trend indicating that the medical center improved its ability to meet its current obligations.

The medical center built its liquidity by increasing its cash account and investing in marketable securities (these activities used 30% of the total cash over the period). With short-term sources, the medical center has 99 days cash on hand – this measure tripled over the period. With the inclusion of unrestricted marketable securities, unrestricted cash balances reached 317 days by 1997. This large discretionary cash balance gives the hospital considerable financial flexibility. (Note: The jump in this measure between 1996 and 1997 resulted from an accounting principle change requiring certain long-term investments to be reported at market value rather than historical cost – this inflated board-designated funds by $2.7M in unrealized gains between these two years.)

Trends in working capital management enhanced the medical center's ability to maintain its cash balances. Growth in the average pay period from 39 to 51 roughly matches the collection period, which remained fairly stable over the period (51 days in 1998).

[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

***Capital Structure***

The medical center is more leveraged than many other New Hampshire hospitals (though it is less leveraged than many hospitals in the US) due mainly to a $36M bond issuance in 1993 and $8M in 1998. Despite increased borrowing in 1998, the hospital's solvency improved over the six-year period due to debt repayment and growth in equity from strong profitability. The equity financing ratio (equity/total unrestricted assets) steadily increased (favorable) and by 1998, more than half of the medical center's assets were financed by equity rather than debt sources (both long- and short-term debt sources). The improvement in these measures between 1996 and 1997 was partially due to the above-mentioned accounting principal change, which increased equity by unrealized gains.

The medical center's ability to cover its debt with yearly income also steadily improved following the trend in profitability. The cash flow to total debt ratio indicates that with increasing profitability, the medical center is able to cover a larger portion of its long-term debt with its yearly total income. This measure was barely affected by the 1998 debt issuance. The debt service indicators also showed a positive increasing trend and illustrate that the hospital can easily cover its debt principal and interest payment, with cash from operating income alone.

Despite the use of debt to augment internally generated capital over the period, the medical center was able to reduce its relative level of debt in its capital structure over the period and to show an improving ability to service its debt.

## Charity Care and Community Benefits

Charity care reported as charges forgone declined steadily over the period. Charges forgone due to charity as a percentage of gross patient service revenues declined from 5 to 2.4 %. This level of charity met the estimated value of the medical center's tax exemption until 1995. In 1996, free care plus 50% bad debt met the estimated tax value. From 1997 to 1998, free care plus 100% bad debt met this benchmark.

The medical center reported contributions totaling $688K to unnamed community programs as an additional charitable activity.

In addition to charity care, the medical center offers neonatal intensive care services, which may be considered an additional charitable benefit to the community[1].

## Cash Flow Analysis 1993 – 1999

From 1993 through 1999, the medical center generated 70% of its cash internally. Operating income was 25% of total cash sources, while the non-operating revenue was 21% of the total cash source. Depreciation was 24%. Net long-term debt was the largest portion of total cash sources at 28%.

Cash was used mostly to invest in property, plant, and equipment (PP&E) (53% of total cash uses). The investment in equipment was 2.2 times the depreciation expense. The average plant life (9.15 years) was slightly below the 75 percentile of the state. Transfers to affiliates used 23% of total cash. Over the seven years, investments in marketable securities represented 18% of total cash uses.

## 1999 Ratio Analysis

### *Profitability*

The medical center's profitability was strong. Total margins increased steadily from 1993 to 1999. This was mainly due to a steady improvement in operating margin. In 1999, total margin decreased slightly, but remained robust at 14%. The operating margin increased from 8% in 1998 to 9% in 1999. The medical center's total margin was at the upper quartile of New Hampshire's 1999 hospital industry.

### *Liquidity*

The current ratio decreased from 2.11 to 1.46. This was due to a decrease in total current assets. The significant decrease in current assets was due to a $12.4 million investment in property, plant and equipment (PP&E) and the transfer of $7.9 million to affiliates. With board-designated investments, the ratio decreased slightly from 4.91 to 4.41. Since the center is financially strong, the center can still meet its current obligations quite easily.

The days accounts receivable increased from 51 to 62 days, and the average pay period to the vendors decreased from 51 days to 45 days. Days cash on hand decreased from 99 days in 1998 to 28 days in 1999, while current days cash including board-designated investments decreased from 318 to 255 days cash.

### *Capital Structure*

The medical center's equity financing ratio increased from 0.55 to 0.58. More than half of the center's assets were financed by equity sources. While the medical center is more leveraged than many other New Hampshire hospitals, it does not have any trouble servicing its debt.

The center's cash flow to total debt was .30 in 1999; while the debt service coverage ratio decreased from 5.56 to 4.34, due to rising levels of current long-term debt. The center was well able to cover its debt principal and interest payment from operating income alone.

**Charity Care and Community Benefits**
Charitable care in the form of forgone charges as a percentage of gross patient service revenue decreased slightly from 2.41% in 1998 to 2.16% in 1999. Bad debt increased slightly during this time from 5.76% to 6.08%.

**Summary**
The medical center's financial performance over the period was strong. Operating profitability drove total margins more than non-operating revenue. The upward trend of profitability, liquidity, and solvency were indicative of the financial health of the center.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health